DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 4

2. STATE: MICHIGAN

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR, Part 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ ~~8,077,595.00~~ 983,150
b. FFY 2002 $ ~~9,070,020.00~~ 1,012,644

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, page 6c ~~6c.1~~

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19, page 6c

10. SUBJECT OF AMENDMENT:
FQHC prospective payment system

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: James K. Haveman, Jr.

14. TITLE: Director

15. DATE SUBMITTED: 3/29/01

16. RETURN TO:
Michigan Department of Community Health
Office of Federal Liaison
6th Floor Lewis Cass Building
320 South Walnut Street
Lansing, Michigan 48913

ATTENTION: Nancy Bishop

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 03/29/01

18. DATE APPROVED: 9/21/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/01

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
APR 02 2001
DMCH - MI/MN/WI

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITEL XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(OTHER THAN INPATIENT HOSPITAL AND LONG TERM CARE FACILITIES)

14. **Federally Qualified Health Center Services**

FQHCs will be reimbursed under one of three methodologies as described below:

(a) an FQHC that is not reimbursed under (b) or (c) below will be reimbursed based on the new Medicaid prospective payment system (PPS) enacted into law under section 702 of the Medicare, Medicaid, and SCHIP benefits Improvement and Protection Act (BIPA) of 2000. Under the PPS, an FQHC will be reimbursed on a per visit basis. The per visit payment will be based on the average of the FQHC's reasonable costs of providing Medicaid services during FY 1999 and FY 2000. Reasonable costs are defined as the per visit amount approved by Medicare as adjusted to reflect the cost of providing services to Medicaid beneficiaries that are not covered by Medicare – i.e., dental services, Maternal/Infant Support services, on-site laboratory and x-ray, substance abuse, non-emergency transportation and outreach.

Effective October 1, 2001, the per visit amount will be adjusted each year using the Medicare Economic Index.

The per visit amount may also be adjusted to reflect changes in the scope of services provided to Medicaid beneficiaries by the FQHC. An adjustment to the per visit amount based upon a change in the scope of services will be prospective and will become effective when the change is approved by the State. The adjustment may result in either an increase or decrease in the per visit amount paid to the FQHC.

FQHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive prospective, quarterly supplemental payments that are an estimate of the difference between the payments the FQHC receives from the MCE and the payments the FQHC would have received under the PPS. At the end of each FQHC's fiscal year, the total amount of the supplemental and MCE payments received by the FQHC will be reviewed against the amount that the actual number of visits provided under the FQHC's contract with one or more MCEs would have yielded under the PPS. The FQHC will be paid the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC, if the PPS amount exceeds the total amount of supplemental and MCE payments. The FQHC will refund the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC, if the PPS amount is less than the total amount of supplemental and MCE payments.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(OTHER THAN INPATIENT HOSPITAL AND LONG TERM CARE FACULITIES)

14. Federally Qualified Health Center Services (continued)

OR

(b) an alternative payment methodology that is agreed to by the State and the FQHC that provides reimbursement at least equal to that which the FQHC would receive under the PPS. If such an alternative payment methodology is agreed to, it will be submitted to HCFA as a State Plan Amendment.

OR

(c) the existing MOA signed by the State and the FQHC if it provides reimbursement at least equal to that which the FQHC would receive under the PPS.

FQHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly State supplemental payments for the cost of furnishing such services, that are an estimate of the difference between the payments the FQHC receives from MCE(s) and the payments the FQHC would have received under the alternate methodology. At the end of each FQHC's fiscal year, the total amount of supplemental and MCE payments received by the FQHC will be reviewed against the amount that the actual number of visits provided under the FQHC's contract with MCE(s) would have yielded under the alternative methodology. The FQHC will be paid the difference between the amount calculated using the alternative methodology and actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC if the alternative amount exceeds the total amount of supplemental and MCE payments. The FQHC will refund the difference between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC, if the alternative amount is less than the total amount of supplemental and MCE payments.

Newly created FQHCs

An entity that first qualifies as an FQHC after fiscal year 2000, will be paid a per visit amount that is equal to 100% of the costs of furnishing such services during such fiscal year based on the rates established under the PPS for the fiscal year or other FQHCs located in the same or adjacent area with a similar case load. If there is no other FQHC similarly situated, the newly established FQHC shall be paid a per visit amount based on an estimate of its reasonable costs of providing such services and cost settled at the end of its first fiscal year of operation. Reasonable costs are defined as the per visit amount approved and paid by Medicare as adjusted to reflect the cost of providing services to Medicaid beneficiaries that are not covered by Medicare – i.e., dental services, Maternal/Infant Support services, on-site laboratory and x-ray, substance abuse, non-emergency transportation and outreach. In subsequent fiscal years, the newly established FQHC shall be paid using (a) or (b) described above.